

Riverbend GBA

RHC

October 2008

Basis of Encounter

The core services of the benefits are professional, meaning the hands-on delivery of care by medical professionals.



All Inclusive Rate

- Payments for covered RHC services furnished to Medicare beneficiaries are made on the basis of an **all-inclusive rate** per covered visit
 - (except for pneumococcal and influenza vaccines and their administration, which is paid at 100 percent of reasonable cost).

A vertical banner on the left side of the slide. It features the word "SOLUTIONS" in large, white, serif capital letters, oriented vertically. Below the text is a photograph of a woman with blonde hair, wearing a light blue medical scrub top, smiling. She is holding a stethoscope around her neck. The background of the banner is a solid dark blue color.

Visit

- The term “visit” is defined as a face-to-face encounter between the patient;
 - physician,
 - physician assistant,
 - nurse practitioner,
 - certified nurse midwife,
 - visiting nurse, clinical psychologist, or clinical social worker
- during which an RHC service is rendered.

Encounters

- Encounters
 - (1) more than one health professional; and
 - (2) multiple encounters with the same health professional which take place on the same day and at a single location, constitute a **single visit**.
- An **exception** occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.



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Solutions

Services

- The core services of the benefit are professional, meaning the hands-on delivery of care by medical professionals.
- Some preventive services are also encompassed in primary care.

RHC Encounters

- Divided into four categories
 - 1.Face-to-face encounters
 - 2.Services incident to the encounter
 - 3.Non RHC services (Part B)
 - 4.Non-covered services (billed directly to the RHC patients)



Basis for Encounter

- For a face-to-face encounter to be medically necessary, providing evaluation and management services at a skill level that requires the assessment, clinical reasoning, and judgment of a qualified RHC practitioner (i.e. the metaphorical "laying on of hands").
- The condition of the patient must warrant the specialized skills of the qualified RHC practitioner





Ancillary

- As a corollary, a visit solely to obtain an ancillary or incidental service does not constitute a medically necessary face-to-face encounter.
- If Medicare covered drugs are furnished by physicians and non-physician practitioners of the RHC to Medicare patients, the drugs must be covered and paid for as RHC services. The costs of such drugs are allowable costs and are part of the clinic's all-inclusive rate calculation.
- You may not bill for drugs that are brought in by the beneficiary.

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Hospital Setting

- The hospital bundling provisions in §1862(a)(14) of the Act provides that Medicare payment may **not** be made to an RHC for services provided to hospital inpatients and outpatients
- If the RHC practitioner should provide services to a hospital patient, these services are not covered under the RHC benefit.



Skilled Nursing Facilities

Services furnished on or after January 1, 2005 section 410 of the Medicare Modernization Act (MMA) of 2003 amended the law to specify that when a SNF Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC those services are not subject to consolidated billing merely by virtue of being furnished under the auspices of the RHC

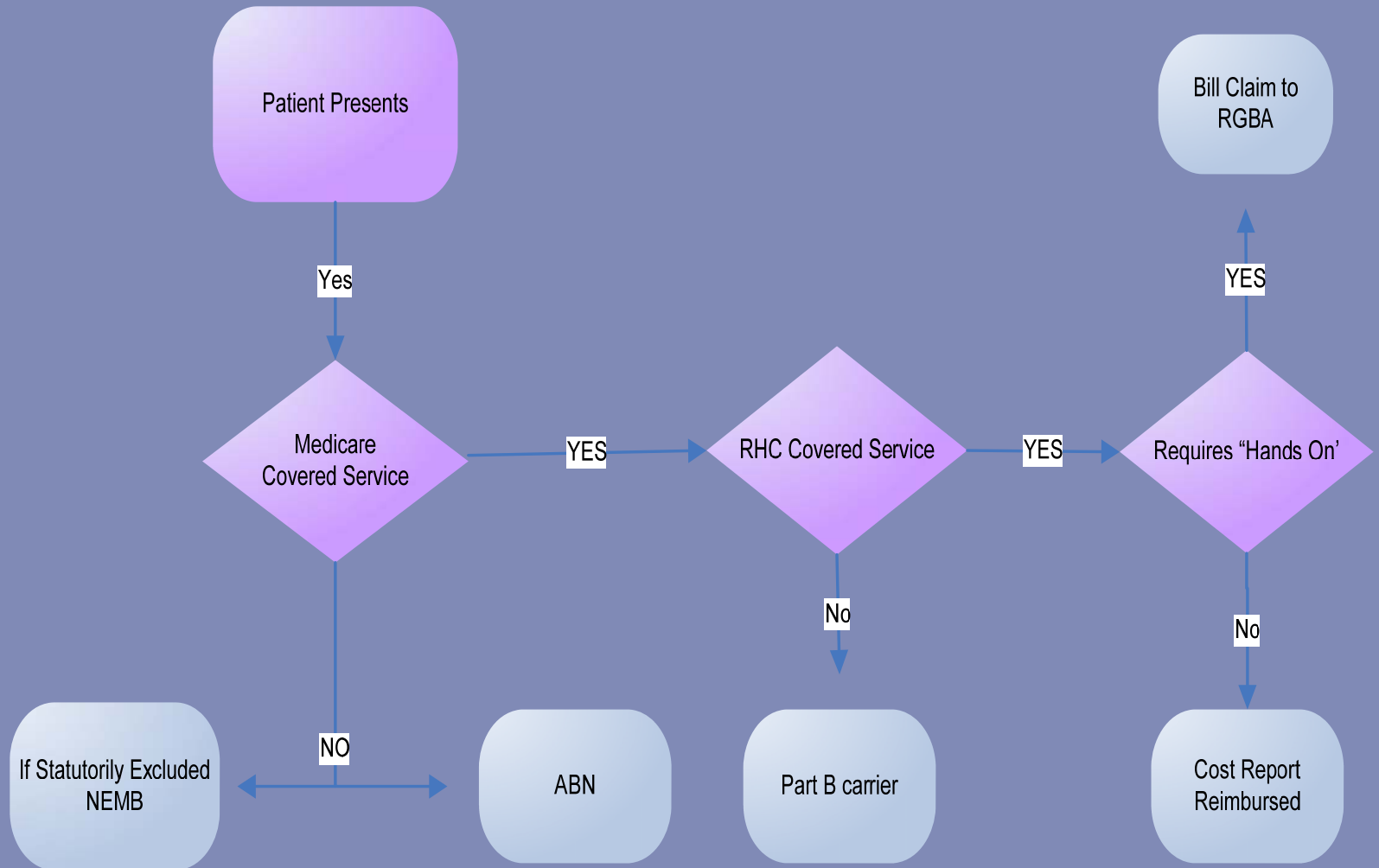
Types of Bill

0710	Non-payment claims (only with non-covered services)
0711	Original claim
0717	Adjustment claim
0718	Cancel prior claim

Revenue Codes

0521	Clinic visit
0522	Home visit
0524	Visit in SNF Part A
0525	Visit to ICF, NF etc
0527	Visiting Nurse Service (very limited)
0528	Scene of an accident
0900	Mental Health (subject to limitation)

Macro Level Decision



Specialty Clinics

- Coumadin Clinics
 - provide primarily non-physician services
 - generate a high level of costs per face to face visit.
 - These services are not prohibited in the RHC environment,
 - Better reimbursement model in non-RHC hours

Specialty Clinics

- These types of clinics do not represent a special benefit category
- Generally lab-based follow up clinics
- Do not demonstrate a need for face-to-face encounter except for follow-up (2 or 3 visits)
- Exceptions are expected to demonstrate a well documented need for the encounter

Specialty Clinics

- Diabetes clinic visits
- Medical complications of the disease are addressed or monitored
- Frequency consistent with standards of care
- Foot care clinics not always medically necessary and non-covered
- Exception with loss of protective sensation

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Chiropractic

- Limited to treatment by means of manual manipulation of the spine for the purpose of correcting a subluxation
- Demonstrated by x-ray or physical examination
- Direct therapeutic relationship to the patient's condition and improve function
- Further service would represent maintenance

Accupuncture

- Never covered
- Statutorily excluded from the Medicare benefit
- Review of services demonstrates acupuncture being performed



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Diabetes Self Management Training

- The CMS will not reimburse services on a fee-for-service basis rendered to a beneficiary if they are:
- An inpatient in a hospital or skilled nursing facility (SNF);
- In hospice care;
- A resident in a nursing home; or
- An outpatient in a rural health clinic (RHC)



Medical Nutrition Therapy

- The applicable bill types are 13x, 14x, 23x, 32x, and 85x.
- MNT Services can only be billed to RGBA when performed in an outpatient hospital setting

Prescription Services

- Visits for the sole purpose of obtaining or renewing a prescription are not covered services
- No exam of the patient was performed



RHC Services

- Units are reported based on encounters
- The encounters are paid the all-inclusive rate *no matter how many services are delivered*
- Only one encounter is billed per day (unless exception)

Welcome to the My.Medicare.gov — The Medicare Beneficiary Portal!

The Medicare Beneficiary Portal allows access to personal information regarding your Medicare benefits and services.

You must be a registered user to access the Medicare Beneficiary Portal. Please select your state/territory (from the drop down list below) to begin registration. Be sure to have your Medicare Identification Number available.

If you have already registered, please [click here](#).

Please select the state/territory you reside in:

Select a State

Important Announcements

Access: Please [Click here](#) to read the latest guide lines on **Pop-Up** blocking software.

Mac Users: Please [Click here](#) for more information about browser compatibility for My Medicare.gov.

Welcome to the Medicare Beneficiary Portal!

This section of the site allows you to access your personal information regarding your Medicare benefits and claims.

You must be a registered user to access this portion of the Medicare.gov website. Be sure to have your Medicare Identification Number available.

[Click Here to Register](#)

Please fill out the information below and click 'Login' to continue.

Login Tips

Fields marked with a red asterisk (*) are required.

*Medicare Number:
*Password:

Please be advised that you only have three (3) attempts to successfully log into the Medicare Beneficiary Portal. After the third (3rd) attempt, you will be temporarily locked out for thirty (30) minutes.

[View Online Services / Web Confidentiality Agreement](#)

Welcome to Medicare Exam

New enrollee for first six months

Covered only once

Deductible and coinsurance apply

Cost Report Reimbursement

- Incident to services
- Services rendered by clinic staff and not requiring the skills of a professional
- Time, supplies and services is captured and recorded in the cost report
- If underpaid check is issued if over paid clinic issues a check

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Cost Report

- RGBA compares the total payment due with the total payments made for services furnished during the reporting period
- If the total payment due exceeds the total payments made, the RHC has been underpaid. The underpayment is made up by a lump sum payment

Medical Review

Agenda

- **Overview of Medical Review**
- **RHC Review Results**



CMS contracts with fiscal intermediaries (FIs)
such as RGBA to perform:

- MR functions

- Data analysis

- Writing local policy

- Review of claims

Note: not all contractors perform Medical
Review (MR) functions




The goal of the Medical Review Program is to reduce the claims payment error rate

- Identifying billing errors concerning coverage and coding
- Take action to prevent and/or address identified errors
- Publish local policies to provide guidance

Medical Review Process

- Data Analysis gathers information from several sources
- Problems are identified
- Providers notified of Claim Selection
- Claims reviewed by clinical audit team
- Provider notified of results





Most errors are not acts that were committed knowingly, willfully or intentionally. Many errors are the result of misunderstanding or failure to pay adequate attention to Medicare Policy

Contractors will take action with appropriate plan of action for the type of error



Medical Review Interventions

- Medical Review of claims
- Referral of provider to Provider Outreach and Education for training
- Provider referred to Program Safeguard Contractor
- Provider referred to Benefit Integrity Units

Medical Review of Claims

Requirements for MR of claims are:

Benefit category review,

Statutory exclusion review,

Reasonable and necessary review, and/or

Coding review



Additional Documentation Request - ADR

Is issued during the medical review process

An ADR must:

- Solicit additional documentation

- Notify provider they have 30 days to respond

- Indicate the specific pieces of documentation needed



Electronic ADR

Direct Data Entry users can monitor claims suspended for “ADR” through the Inquiry menu. Access option 01, then option 12. Enter SB6001 in the S/LOC field and depress the enter key.

Select your claim for review, and the last page will display the ADR letter generated to your facility.

Non DDE users can monitor the same information via the 201 report.

Additional Documentation Request includes

45-day limit for records to reach Riverbend

Mandated by CMS, claims must be denied that are not received by Riverbend on or before the 45th day following the date the ADR was generated

Medicare Program Integrity Manual

If no response is received within 45 days after the date of the request, the contractor shall deny the service as not reasonable and necessary.

Denials are issued with remittance advice code 56900 “This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.”

Medical Review Results

New Providers

Service specific reviews

Provider specific reviews



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New RHC Providers

Approx 40 claims

Evaluated to determine if additional claims are necessary

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Service Specific Reviews

- Multiple Providers
- Review of RHC clinic visit

Documentation in the RHC

- Documentation should chronologically record the care of the patient and is important element that contributes to high quality of care
- Ability of the physician/others to evaluate and plan the patient's immediate treatment, and outcomes, and monitor care over time
- Communication and continuity of care among physicians/others involved in patient care
- Accurate and timely claims review and payment
- Appropriate utilization review
- Collection of data that may be useful in research and education



Documentation

- The Code of Federal Regulations (42 CFR 491.10) sets forth minimum requirements for records:
 - Reports of physical examination
 - Diagnostic and laboratory test results
 - Consultative findings
 - Physician orders
 - Treatment and medications
 - Any other pertinent information

Documentation in the RHC

- Medical Record should be complete and legible
- Each patient encounter should include
 - reason for the encounter with relevant history, physical examination and prior diagnostic test results
 - assessment, clinical impression/diagnosis
 - plan of care; and
 - date and legible identity of the observer



Key Components

- History
- Examination
- Medical decision making



Additional Documentation Request

***** CONFIDENTIAL *****
ADDITIONAL INFORMATION WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED FOR THIS CLAIM. PLEASE COMPLETE AND FOLLOW THE INSTRUCTIONS LISTED BELOW. THE INFORMATION/ADDITIONAL DOCUMENTATION SHOULD BE ATTACHED BEHIND THIS REQUEST AND SUBMITTED WITHIN 45 DAYS TO THE ADDRESS LISTED BELOW. FAILURE TO SUBMIT THE DOCUMENTATION BEHIND THE REQUEST COULD RESULT IN INAPPROPRIATE HANDLING OF YOUR CLAIM.
IF THIS REQUEST IS FROM THE MEDICAL REVIEW DEPT AND THE MEDICAL RECORDS ARE NOT RECEIVED WITHIN 45 DAYS OF THE DATE OF THIS REQUEST THE CLAIM WILL BE DENIED. THE NEXT LEVEL OF REVIEW WILL BE THE APPEALS PROCESS. ALL PUBLICATIONS INCLUDING INFORMATION FOR THE CORRECT SUBMISSION OF MEDICAL RECORDS CAN BE FOUND AT WWW.RGBAGOV.COM. (OMB # 0938-0969)

RIVERBEND GBA MEDICAL REVIEW DEPARTMENT
P.O. BOX 6098
CHATTANOOGA TN 374016098

MEDICAL REC NO. DCN	PATIENT NAME/ HIC NUMBER	FROM/TO DATES	OPR-MED ANALYST	TOTAL CHARGE
		020108	M899	2,835.
		022908		

REASONS: 58BGM

58BGM

THIS CLAIM HAS BEEN SUSPENDED FOR A REVIEW OF OUTPATIENT REHABILITATION SERVICES DUE TO THE RESULTS OF A PREVIOUS AUDIT, WHICH INDICATED THE NEED FOR FURTHER REVIEW. THIS REVIEW IS SPECIFIC TO YOUR PROVIDER NUMBER. IF YOU HAVE ANY QUESTIONS REGARDING THIS REQUEST FOR MEDICAL RECORDS, CALL 1-877-296-6189.

1. PHYSICIAN ORDERS
2. PROGRESS NOTES
3. HISTORY AND PHYSICAL
4. CERTIFICATION/RECERTIFICATION SIGNED BY MD AND THERAPIST
5. DIAGNOSTIC REASON FOR SERVICES PERFORMED
6. THERAPIST NOTES (INCLUDE INITIAL AND CURRENT EVALUATIONS, PLAN OF CARE, TREATMENT PLAN, ANY WOUND TREATMENT DOCUMENTATION) SIGNED, DATED BY MD AND THERAPIST
7. DOCUMENTATION TO VERIFY DAILY MINUTES AND UNITS BILLED
8. DISCHARGE SUMMARY
9. ANY PERTINENT DOCUMENTATION TO SUPPORT MEDICAL NECESSITY OF SERVICES BILLED
10. DETAILED, ITEMIZED CHARGES FOR THE DATES OF SERVICE BILLED

Key Components

- Face-to-face encounters must have appropriate identifiable signature
 - Record must end with the signature of the provider rendering the service
 - Physician/Practitioner registry
 - Patient must be identified on all papers in the chart. (treatment notes, progress notes, nursing notes, test results, etc)



Key Components

- Name of clinic or physician/practitioner name and telephone number on all records
 - Date on which the encounter occurred
 - In the case of multiple visits (exception) date and time of visit
 - Process in place for producing, assembling, mailing records requested for review in a timely manner



Reason for Referral: Check-up

Current Medication:

Dosage:

1. Cozaar 50 mg 1 tab daily
2. Therapeutic M-ads 1 tab daily
3. Naproxen 1 tab daily BID
4. Sulfadrim 200 ^{40/5} 1-2 TSP daily
5. Fluoxetine 40mg 1 tab daily
6. Tegretol XR 200mg 1 tab BID
7. Topamax 100 mg 1 tab in am
8. 2 tabs in PM

Current Medication:

Dosage:

9.

10.

11.

12.

13.

14.

15.

16.

Physician: Please review list of medications for any contra-indications due to medication combinations.

Diagnosis:

HTN-C

Services Provided/Recommendations:

STOP NARCOYN.

COTEX BID IF POSSIBLE weekly

3/10
RETURN APPOINTMENT DATE

[Signature]
SERVICE PROVIDER SIGNATURE



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[illegible]